IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
WESTERN DIVISION

MICHAEL EUGENE COLTHARP **PLAINTIFF**

VERSUS **CIVIL ACTION NO. 3:98CV029-P-A**

MIDSOUTH BENEFIT ADMINISTRATORS, INC., STANDEX INTERNATIONAL CORPORATION, a Delaware Corporation, and BAPTIST MEMORIAL HOSPITAL

MEMORANDUM OPINION

This cause is before this Court on a Motion for Summary Judgment filed by defendant Baptist Memorial Hospital, [45-1], and on defendants Midsouth Benefit Administrators, Inc.'s and Standex International Corporation's Motion for Summary Judgment, [47-1]. The Court, having reviewed the motions, the briefs of the parties, the authorities cited and being otherwise fully advised in the premises, finds as follows, to-wit:

FACTUAL BACKGROUND

Michael Coltharp was an employee of Standex International Corporation (MasterBilt) from October 1979 through September 1993. Beginning August 1, 1993, Coltharp's employer provided him with medical benefits pursuant to an employee benefit plan governed by ERISA. The plan was supervised by Midsouth Benefit Administrators, Inc. (Midsouth).

At the time he elected to participate in the plan, Coltharp participated in an orientation meeting designed to familiarize employees with the basic contours of the medical package; at that time, plaintiff was also provided with a plan description which outlined the benefits and coverages, as well as enumerating the physicians and hospitals participating in the preferred provider organization (PPO). He was also provided with a schedule of benefits which explained that the plan afforded reimbursement for inpatient services at the following rates: 100% for North

Mississippi Medical Center; 80% for services received at Baptist Hospital-Union County; and 50% reimbursement rate for "all other non-preferred hospital systems."

Coltharp suffered a severe fracture of his right leg on September 26, 1994. He initially sought treatment at Baptist Hospital-Union County and was advised that Baptist Hospital -Union County could not provide effective treatment for his injury. Coltharp was referred to Oxford, Mississippi for treatment. Dr. Wayne Terry Lamar[1] met Coltharp at Baptist Memorial Hospital's emergency room; after evaluating Coltharp's condition, Dr. Lamar ordered his immediate admission as an inpatient. Dr. Lamar performed surgery on Coltharp's leg a few days later and Coltharp was discharged on October 5, 1994.

Coltharp saw Dr. Lamar for several follow up visits. Then, on October 31, 1994 he saw Dr. Lamar for an unscheduled visit after noticing an odor and drainage emanating his wound site. Dr. Lamar discovered a serious infection and told Coltharp to report immediately to the Baptist Memorial Hospital (Oxford) for admission. Dr. Lamar advised Coltharp and his family of the gravity of Coltharp's condition and warned that amputation could be the end result. Coltharp entered the Oxford facility on October 31, 1994 and remained there until November 14, 1994.

While there, Greg Barber, an employee of MasterBilt, called Coltharp to advise him that his stay at Baptist was only covered at a 50% reimbursement rate. Coltharp allegedly began efforts to obtain a transfer to the North Mississippi Medical Center so that his medical plan would cover his expenses at the 100% reimbursement rate. He testified in deposition that he

[1] The record is unclear concerning whether Coltharp was specifically referred to Dr. Lamar or to Baptist Memorial Hospital. In any event, Dr. Lamar, and other physicians who shared a practice with Lamar, had treated Coltharp for previous, unrelated complaints. Dr. Lamar was a participating preferred provider under the plan.

asked someone in administration at Baptist (Oxford) how to accomplish the transfer. He further testified he was told he would first have to find a physician willing to undertake his care at the Tupelo facility. Coltharp further testified that he engaged in efforts to do so, but was unsuccessful. Coltharp was unable to recall the name of the individual in administration with whom he spoke, nor was he able to recall the names of any physicians he contacted concerning treatment and transfer.

Coltharp never asked Dr. Lamar to refer him to another physician in order to facilitate his transfer to the PPO facility in Tupelo. He did, however, seek Dr. Lamar's assistance in obtaining an evaluation from a wound clinic in Birmingham during this same period. Dr. Lamar acquiesced and made the arrangements; on November 15, Coltharp was transferred by ambulance to the Birmingham facility. Following the evaluation, a physician at the Birmingham clinic gave Coltharp an uncertain prognosis regarding whether alternative treatment might arrest the infection and thus avoid amputation.

Coltharp ultimately decided to go forward with a below knee amputation of his right leg. He was readmitted to Baptist (Oxford) on or about November 17, 1994 and Dr. Lamar performed the amputation the following day. A few days later, he was discharged.

The total charges incurred during Coltharp's stay at Baptist from October 31, 1994 through November 21, 1994 were in excess of $28,000.00. Midsouth Benefits Administrators paid Baptist $13,954.10 at the 50% reimbursement rate for nonparticipating providers as outlined in the employee benefit plan. In February 1995, Coltharp entered into an agreement with Baptist to pay the balance due in installments of $50.00/month.

The "Plan" provided for an appeal of decisions concerning benefits determinations.

Employees had 60 days in which to appeal a benefits decision. Coltharp never requested reconsideration of Midsouth's benefits determination until some two years later; at which time Coltharp's attorney telephoned Midsouth and wrote letters questioning Midsouth's determination that benefits were only payable at the 50% reimbursement rate. Despite Coltharp's untimely request, Midsouth reevaluated its benefits determination in light of Coltharp's claim that his hospital stay was precipitated by an emergency, thereby entitling him to payment at the higher PPO rate. Despite the reevaluation, Midsouth and MasterBilt affirmed the benefits decision.

Coltharp filed suit in the Circuit Court of Lafayette County, Mississippi on November 25, 1997, asserting numerous state law claims[2] against Midsouth Benefit Administrators, Inc., Standex International Corporation and Baptist Memorial Hospital[3]. The defendants timely removed the suit to the United States District Court for the Northern District of Mississippi on the ground that the benefit plan at issue is governed by ERISA. All defendants seek summary judgment, albeit on separate grounds.

LEGAL ANALYSIS

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[2] Plaintiff asserts breach of contract, bad faith, breach of fiduciary duty, and negligence against defendants Midsouth and MasterBilt. He asserts claims of negligence and malicious interference with contract against defendant Baptist Hospital. In all, plaintiff seeks $100,000 compensatory damages plus pre-judgment interest, attorney's fees and damages for emotional distress. Plaintiff also asserted a right to punitive damages, a claim which has since been addressed by defendants' successful motion for summary judgment.

[3] Baptist Memorial Hospital has since filed a counterclaim for the balance owing for plaintiff's 1994 hospitalizations. It filed no motion for summary judgment as to the counterclaim; hence, the counterclaim remains to be adjudicated despite our decision on Baptist's motion.

1. Mid-South's Motion for Summary Judgment[4]

Mid-South seeks summary judgment on two alternative grounds: 1) plaintiff's inability to bring forward proof of the essential elements of his claims of negligence and malicious interference with contract; and 2) statute of limitations. These are addressed in the order raised by defendant.

a. Malicious Interference with Contract

A claim for tortious interference with contract lies where a "defendant maliciously interferes with a valid and enforceable contract, thereby causing one party not to perform and resulting in injury to the other contracting party." Mid-Continent Telephone Corp. v. Home Telephone Co., 319 F. Supp. 1176, 1199-1200 (N.D. Miss. 1970). Requisite elements of the cause of action are:

1. Intentional and willful acts;
2. Calculated to cause damage to the plaintiff's lawful business;
3. Done for an unlawful purpose of causing damage, without right or justifiable cause; and
4. In fact causing such a loss.

Cenac v. Murry, 609 So.2d 1257 (Miss. 1992).

Baptist argues that the evidence simply does not support a finding that it interfered in any way with Coltharp's contract for medical benefits. This Court concurs. The bare allegations of the Complaint are not borne out by the facts. No Baptist personnel ever attempted to interfere in

[4] Despite the removal context, the plaintiff's claim against Baptist is grounded solely on state law due to Baptist's having no relationship with the administration of the benefit plan.

Coltharp's attempts to perform or otherwise obtain benefits under the MasterBilt Health Plan. Nor can Coltharp's purported communications with hospital administration suffice as the requisite showing. At most, hospital personnel correctly communicated that transfer was contingent on plaintiff's finding a physician willing to undertake his care at the PPO hospital. Furthermore, the only evidence of record indicates that Baptist Hospital personnel cooperated in Coltharp's efforts to transfer to a facility in Birmingham for evaluation and possible treatment. Plaintiff also fails to make any showing which tends to prove that the hospital's alleged acts were intended to interfere with plaintiff's receipt of maximum medical benefits under his contract with MasterBilt or that such acts were undertaken with the required intent to cause harm to plaintiff.

b. Negligence

The Complaint also alleges negligence as a theory of recovery. Horn book law teaches that in order to recover for negligence, a plaintiff must prove the defendant owed him a legal duty and that said duty was breached; and that the breach resulted in damage to the plaintiff. Hardy v. K-Mart Corp., 669 So.2d 34, 37 (Miss. 1996). A claim of negligence must be founded upon a defendant's particular act or omission, rather than conclusory assertions. McWilliams v. City of Pascagoula, 657 So.2d 1110, 1111 (Miss. 1995). The Complaint delineates no such specific duty; plaintiff's failure to respond to Baptist's motion for summary judgment makes it impossible to determine what duty Baptist might have failed to meet, let alone how the facts demonstrate a breach.

Because plaintiff has failed to meet his burden of coming forward with significant probative evidence which establishes the existence of a triable issue of fact as to his claims

against Baptist Memorial Hospital, said defendant's motion is well-taken and should be granted.[5]

2. Joint Motion for Summary Judgment of Midsouth Benefit Administrators, Inc. and Standex International Corporation

Defendants Midsouth and Standex (MasterBilt) also seek summary judgment, asserting that plaintiff failed to exhaust administrative remedies.[6] The motion also addresses plaintiff's claim on its merits, asserting that the evidence does not evince a breach of fiduciary duty. Defendants Midsouth and MasterBilt contend Coltharp is incapable of demonstrating that their interpretation of the plan was not "legally correct." Nor can he, they argue, demonstrate an abuse of discretion–a showing plaintiff must make in order to establish a right to recovery under ERISA[7].

a. Standard of Review under ERISA

A district court's review of a plan fiduciary/administrator's benefits determination differs depending on whether the claimant's objection is grounded on a factual determination or on an

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[5] Because the Court disposes of the claims against Baptist Memorial Hospital on other grounds, it is not necessary for the Court to address Baptist's statute of limitations argument.

[6] The Court would simply note that Coltharp's failure to timely appeal the benefits decision does not preclude his suit. Applicable case law merely prohibits the bringing of suits when no review of the benefits decision has yet been sought. See Hall v. National Gypsum Co. 105 F.3d 225 (5th Cir. 1997); Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980); Goodman v. S & A Restaurant Corp., 821 F. Supp. 1139 (S.D. Miss. 1993). Defendants admit, however, that they conducted a review of the benefits determination despite the untimely nature of Coltharp's request. Hence, Coltharp has exhausted his administrative remedies and this suit is properly before the Court. Furthermore, to the extent that any further analysis is necessary, the Court hereby finds that, in view of the defendants' apparent predisposition toward denying/limiting payment of Coltharp's claim, administrative review would have been futile. See Denton v. First National Bank of Waco, 765 F.2d 1295 (5th Cir. 1985).

[7] Coltharp's state law claims are preempted under ERISA. 29 U.S.C. § 1144. See Goodman v. S & A Restaurant Corp., 821 F. Supp. 1139 (S.D. Miss. 1993). Therefore, plaintiff has only a claim for benefits denied him under the plan pursuant to 29 U.S.C. § 1132(a)(1)(B)

interpretation of the plan's terms. In every instance, factual determinations are to be reviewed under an abuse of discretion standard and only upon the administrative record. Plan interpretations, on the other hand, are reviewed differently depending on whether the plan vests the fiduciary/administrator with a discretionary function in that regard. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 956-57 (1988). In the instant case, the plan provides that "[t]he Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions, including, but not limited to, all issues concerning eligibility for and determination of benefits." Accordingly, an abuse of discretion standard also applies to this Court's review of any of the defendants' acts which might reasonably be construed as plan interpretation.[8]

Where a benefits decision turns on plan interpretation, a two-tier analysis is involved. First, the trial court must determine whether the administrator's plan interpretation is "legally correct." Factors to consider in evaluating the legal accuracy of the administrator's plan interpretation include the following:

1. Whether the administrator has given the plan a uniform construction;
2. Whether the interpretation is consistent with a fair reading of the plan; and
3. Any unanticipated costs resulting from different interpretations of the plan.

Wildbur v. ARCO Chemical Co., 974 F.2d 631, 638.

If the Court determines that the administrator's interpretation of the plan is legally correct, the

[8] Had the plan not included a grant of discretion, plan interpretation would be reviewed *de novo*.

analysis need proceed no further. However, should the Court conclude otherwise, it becomes necessary for the Court to embark on an inquiry aimed at determining whether the administrator abused its discretion in reaching the benefits determination at issue. The abuse of discretion inquiry turns on the following considerations:

1. The internal consistency of the plan under the administrator's interpretation;
2. Any relevant regulations formulated by the appropriate administrative agencies; and
3. The factual background of the determination and any inferences of lack of good faith.

Id.

Where a factual determination is at issue, the Court's role is limited to determining whether the administrator reached a reasonable and impartial decision in light of the evidence with which it was presented. Goodman v. S & A Restaurant Corp., 821 F. Supp. 1139, 1145 (S.D. Miss. 1993). The case law is replete with admonitions that the district court is not to substitute its judgment for that of the plan administrator–i.e., the inquiry is whether the plan fiduciary abused its discretion in arriving at the benefits decision, not what the district court would have done had it been in the administrator's position.[9] Pierre v. Connecticut General Life Ins. Co., 932 F.2d 1552, 1559 (5th Cir. 1991)("The courts simply cannot supplant plan

[9] In the current procedural posture (summary judgment motion), a plaintiff must demonstrate the existence of genuine issue of material fact. In order to do so where the plaintiff's case turns on a plan administrator's alleged abuse of discretion, a plaintiff must demonstrate "that in making those choices and judgments, the administrator acted without any substantial basis . . . (and/or that the administrator failed to render a decision that was impartial)." Goodman v. S & A Restaurant Corp., 821 F. Supp. 1139, 1144 (S.D. Miss. 1993).

administrators, through de novo review, as resolvers of mundane and routine fact disputes."). Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th. Cir. 1993); Rutledge v. American General Life and Accident Ins. Co., 914 F. Supp. 1407, 1410 (N.D. Miss. 1996). However, aside from the administrator's determination of the "historical facts" underlying the benefits determination, the weight of authority approves the consideration of evidence in addition to the administrative record in applying the other abuse of discretion criteria. Wildbur v. ARCO Chemical Co., 974 F.2d 631, 638-39 (5th Cir. 1992)("[W]e now make manifest that a district court is not confined to the administrative record in determining whether, under our analytical framework, a plan administrator abused his discretion in making a benefit determination.").

b. Plan Interpretation

Coltharp's complaint alleges the defendants wrongfully limited reimbursement for his second hospitalization to 50%, alleging that the October 31, 1994 hospitalization which led to his November 18, 1994 below knee amputation was an emergency, thereby entitling him to reimbursement at the higher PPO rate. The benefits determination necessarily involved both plan interpretation and factual findings on the part of the plan administrator/fiduciary. The determination was based on the following plan provision:

> This plan provides benefits through a Preferred Provider Organization (PPO). . . . Covered services obtained from a non-PPO provider . . . will be covered at the PPO benefit level only under the following circumstances: (1) In the event treatment is for an accident or emergency medical condition as defined in this Plan, and (2) for services obtained outside of the PPO service area as defined in the Plan's then current PPO contract and as may change from time to time, and (3) upon referral from a treating PPO provider.[10]

[10] The provision of the plan which explains conditions under which treatment by a non-participating provider will be paid at the higher PPO rate is ambiguous in that it is impossible to determine from mere reading whether all of the listed circumstances must be met in order to

Under the section of the plan styled "DEFINITIONS," emergency is defined as "[a] sudden, unexpected acute medical condition that, without medical care within 48 hours of onset, could result in death or cause serious impairment of bodily functions."

Midsouth avers that it considered the available medical records and the pre-certification recommendation from Crawford and Company in concluding that Coltharp's October 31, 1994 hospitalization was not an emergency. It concluded instead that the hospitalization "arose directly from the injury he received on September 26, 1994 and from the ongoing care that he had been receiving for a condition that gradually worsened." Nunley Affidavit at paragraph 28.

Midsouth and MasterBilt base their decision on an altogether erroneous proposition: i.e., that a beneficiary such as Coltharp, who is convalescing from recent surgery, cannot experience a decline so "sudden" and "unexpected" that it meets the plan's definition of "emergency." Certainly the plan language includes no indication that complications which set in nearly four weeks following surgery, when most patients have set aside all such concerns, would be excluded from coverage as an emergency. Neither does the plan contain language which in any way suggests an emergency need arise from a cause independent of any preexisting medical condition or from an injury sustained prior to the onset of the emergency condition, as inferred by Midsouth's conclusion that the condition "arose directly from the September 26, 1994 injury."

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warrant an exception or whether any one will do. It would appear that the conditions listed are in the alternative, given the language that the higher payment rate applies in the following "circumstances," rather than the singular "circumstance." In any event, consideration of this factor is unnecessary to the Court's decision inasmuch as the defendants have presented no argument that the last two provisions are at issue.

In fact, such an interpretation imports elements of the definitions of "accident"[11] and "injury"[12] which are not apparent upon a fair reading of the plan definition of "emergency."

In sum, this Court is satisfied that there exist genuine issues of material fact concerning whether the plan administrator/fiduciary engaged in a legally correct interpretation of the plan in making the benefits determination concerning Coltharp. The foregoing analysis raises numerous questions concerning whether the plan was given a uniform construction and whether the interpretation employed was consistent with a fair reading of the plan. There is no evidence before this Court concerning what financial effect a contrary interpretation might have on the plan.[13]

c. Factual determination

While giving all due deference to the plan administrator, summary judgment is simply inappropriate in this case. The available medical records show no indication that Coltharp's October 31, 1994 hospitalization and the subsequent amputation were the result of a "condition that gradually worsened." The medical records from Coltharp's visits to Dr. Lamar after his initial October 5, 1994 discharge indicate nothing which suggests Coltharp was experiencing anything other than a normal convalescence. On each of three follow up visits prior to October

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[11] "A bodily injury sustained independently of all other causes, that is sudden, direct and unforeseen and is exact as to time and place."

[12] "A condition caused by accidental means which results in damage to the Covered person's body from an external force."

[13] While Nunley's affidavit attempts to address this issue, it is directed more at what effect payments at the higher PPO rate would have were they permitted in cases not meeting the emergency conditions outlined in the plan–rather than the more appropriate inquiry concerning what effect a differing, albeit slightly broader, interpretation of emergency might have on the plan's assets.

31, 1994, the medical records specifically note no sign of infection.

Furthermore, the facts brook no argument that Coltharp's condition did not otherwise meet the definition of a medical emergency as defined by the plan–especially in light of the ultimate outcome. Dr. Lamar's October 31, 1994 notes referenced Coltharp's prognosis as "grave." Crawford and Company certified Coltharp's October 31, 1994 admission as "urgent." Midsouth and MasterBilt state in their joint brief that the term "'urgent' is a term of art which does not connote an 'emergency medical condition.'" However, they offer no substantiation for that position, despite the fact that reference to a thesaurus reveals the terms to be synonymous.

Finally, defendants' argument that Coltharp's condition had been ongoing for in excess of 48 hours prior to October 31, 1994 unfairly places the onus of recognizing and diagnosing an emergency medical condition on the plan beneficiary.[14] Plaintiff sought prompt medical treatment after noting drainage from his wound site. Coltharp should not be penalized for his failure to realize that medical intervention may have been warranted prior to that time.

In addition to the administrative record which points only to the conclusion that the infection which necessitated plaintiff's October 31, 1994 hospitalization was unexpected and of sudden onset, additional factors suggest an abuse of discretion by the administrator/fiduciary. Midsouth places undue emphasis on several factors unrelated to whether Coltharp's condition warranted categorization as an emergency. Defendants' brief in support of the instant motion includes a lengthy sermon on Coltharp's "decision" to seek treatment at a non-PPO facility at the time of his September 26, 1994 injury–-pointing out Coltharp's refusal to accept transfer to

[14] This factor is equally applicable to the Court's analysis concerning plan interpretation. A reasonable construction of the plan's provisions cannot be said to impose such a heavy burden on a plan beneficiary.

Oxford via ambulance and the fact that the non-PPO facility was further away[15] than the preferred facility as evidence that his use of the non-PPO facility was voluntary. Defendants also construe plaintiff's failure to question his referral to the Oxford facility against him and wield plaintiff's familiarity with Dr. Lamar in furtherance of their argument. None of these "facts" address the ultimate question Midsouth and MasterBilt were called upon to answer: i.e., whether the plaintiff's admission to Baptist Hospital (Oxford) on October 31, 1994 was for an emergency?

Likewise, defense counsel's argument concerning plaintiff's decision to investigate treatment alternatives at another non-PPO facility, and in defendants' eyes yet again eschewing treatment at NMMC, does not support a finding that Coltharp's medical condition was not an emergency. Coltharp was faced with the unpalatable likelihood of amputation; his altogether reasonable decision to seek a second opinion before submitting to such a surgery cannot be marshaled in support of the proposition that his hospitalization at Baptist (Oxford) was compelled by anything short of an emergency.

Finally, defendants' argument is rife with inconsistency. Their entire argument is replete with characterizations of Coltharp's hospital stay as voluntary–i.e., he "chose" to go to a non-PPO facility, rather than to seek treatment at a preferred facility. Defendants' bent, for lack of a better word, betrays an impartial bias <u>against</u> a finding of an emergency condition. Nowhere is this more evident than in the portions of Nunley's affidavit addressing the internal consistency of

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[15] The Court likewise refers back to the plan interpretation analysis: nothing in the terms of the plan remotely suggests that payment at the higher PPO rate for emergency treatment is conditioned on the plan member's seeking treatment at the facility geographically nearest the situs of an accident.

the plan:

> Mr. Coltharp's suggestion that he is entitled to higher, PPO coverage because he had a serious injury and chose to drive himself away from a PPO-covered facility to a non-PPO facility, then later to return to that same facility for lengthy, continued treatment leading to surgery, has never been asserted under Master-Bilt's Plan, before or subsequent to this incident, so far as I am aware.

Affidavit of Nunley at paragraph 43.

The same can be said for defendants' argument concerning the forewarning given plaintiff as to the rate of reimbursement which applied to his hospitalization at Baptist (Oxford). Greg Barber's call is a blatant suggestion of bad faith: defendants had already predetermined that the 50% reimbursement rate would apply before they had examined the pertinent medical evidence.

Instead of focusing on the available medical evidence, defendants relied instead on what they perceived to be Coltharp's internal motivation for seeking treatment at the non-PPO facility. Again, the plan authorizes treatment and reimbursement at higher rates at a non-PPO facility in instances of emergency. There is no requirement, express or implied, that approval of benefits at the PPO rate engenders a subjective inquiry into where a beneficiary might have preferred to obtain treatment. The existence of an emergent condition--alone--warrants a departure from plan limitations pertaining to reimbursement rates.

All of the foregoing are indicative of an evidence of abuse of discretion and of defendants' clear preference for an interpretation of the plan which favored the fiduciary over plan beneficiaries, in this case Mr. Coltharp. For the foregoing reasons, summary judgment is not appropriate.[16]

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[16] Defendants' brief devotes a small portion to an apparent argument that Midsouth had no discretion in interpreting or applying the terms of the plan–i.e., that it was simply contracted to perform the day-to-day administrative functions and that it had no financial interest in decisions

CONCLUSION

In accordance with the foregoing analysis, Baptist Memorial Hospital's Motion for Summary Judgment is well-taken and should be GRANTED. The joint motion of Midsouth and Standex is not well-taken and should be, and hereby is DENIED. This Court will enter appropriate orders herein.

This, the _____ day of November, 1999.

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W. ALLEN PEPPER, JR.
UNITED STATES DISTRICT JUDGE

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under the plan. Construing the facts in the light most favorable to plaintiff, Midsouth's recommendations were at the heart of the claims decisions in this case. To the extent that Midsouth seeks summary judgment on this ground, the motion is not well-taken and should be denied.